King County

Department of
Community and Human Services

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FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 2.4(a)
Housing Health Outreach Team

1. **Goal (Overarching Investment Strategy)**
   The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of ending homelessness through outreach, prevention, permanent supportive housing and employment (page 18 of SIP).

2. **Objective (Specific Investment Strategy)**
   Increase the availability of services for existing or new permanent housing (page 20 of SIP).

3. **Population Focus**
   This program prioritizes single adults and families in Seattle and South King County who are chronically homeless and who are making the transition into supportive housing. This is one of the primary target populations of the Veterans and Human Services Levy (V-HS Levy). The client population to be served by the team characteristically have mental health and substance abuse conditions (including post traumatic stress disorder), and many are veterans of the U.S. military.

4. **Need for Services**
   The objective of this investment is to assure that appropriate health care linkages and supports are included in permanent supportive housing projects, so that the tenants can establish a regular health care regimen, rather than relying on costly emergency care. Health care and wellness services are cited by the Corporation for Supportive Housing as among those that are needed in supportive housing for homeless people.

   Health Care for the Homeless Network (HCHN) in Public Health-Seattle & King County (PH-SKC) has experience coordinating on-site services in shelters and transitional housing sites, and proposes to apply that model through the Housing Health Outreach Team (HHOT) at supportive housing sites being developed for high-need households. In addition, HCHN has a great deal of experience serving veterans in shelters and case management programs and maintains data on those veterans served. In 2006 they provided service to 446 unduplicated homeless veterans.

Residents in "housing first" programs and permanent supportive housing experience a wide range of health concerns, exacerbated by poverty and a history of lack of access to adequate health care. Chronic health conditions such as diabetes, hypertension, hepatitis C, asthma, mental illness, and chemical dependency are common.

Veterans are part of the specific target group for the supportive housing developments and thus for the HHOT. Estimates of the percentage of homeless individuals who are veterans of the US armed services ranges from about 30-40 percent. The National Coalition for Homeless Veterans estimates that 76 percent of veterans suffer from alcohol, drug, or mental health problems. Post-traumatic stress disorder (PTSD) is relatively common among homeless adults, and is particularly common in homeless veterans. A specific focus of the HHOT will be to ensure that the health needs of veterans are addressed, and the HHOT is planning to partner with veteran-serving organizations. The HHOT partnership has already had one discussion with the King County Veterans Program regarding options for partnering. We anticipate that at least 30 percent of the clients supported by the HHOT will be veterans or family members of veterans. HCHN currently collects veteran status, and can modify its data collection form to add any needed data elements for Levy evaluation.

5. Funds Available

HHOT: Of the $2.5 million in 2007 and 2008 funds for operating and services in permanent housing, $250,000 annually will be managed through the HCHN of PH-SKC to organize on-site nursing and health services for persons with high needs at selected supportive housing sites; of that amount, $75,000 is available for veterans and $175,000 for others in need.

6. Program Description

Mobile Community Health Team – $250,000 will used annually to support this project of the HCHN to extend on-site health services into permanent supportive housing for homeless people.

Building on its extensive history of providing interdisciplinary health services in homeless shelters, HCHN is proactively shifting its model to support the *Ten-Year Plan to End Homelessness in King County* and the goals of the V-HS Levy. The new program area is called the "Mobile Community Health Team" or HHOT. HCHN's model is to contract with community-based agencies who in turn hire the staff to provide the direct clinical services.

The HHOT will deliver health services on-site in selected supportive housing buildings that are taking high-need homeless people, including veterans, with challenging health issues into their units, working closely with funders and housing providers to seek out and target those sites with the highest need. The HHOT will prioritize support to those housing sites funded by Veteran's & Human Services Levy, King County, and/or the City of Seattle that have set-aside units for persons moved directly from the streets into permanent housing ("housing first"), and that have units for veterans. HHOT services will be provided at both existing and new housing sites. In this context, "mobile" means that the team serves multiple housing sites.

The HHOT will ensure that services are provided to the appropriate percentage of veterans in the housing units served, and will help them access Veteran Administration (VA) health services, including primary and specialty health care, counseling for PTSD and other mental health issues, chemical dependency treatment, and other services for which veterans are entitled if VA services are desired. Veterans will also be linked to health supports outside the VA system, as needed.

The HHOT chemical dependency case managers will be trained practitioners in Seeking Safety, an evidence-based treatment model used in treatment of PTSD and substance abuse, both highly prevalent issues for homeless people and veterans.

Project management: HCHN has responsibility for oversight of the HHOT team as a whole, assuring effective partnerships with the various funders and implementing agencies, and leading a project Steering Committee. HCHN will negotiate and monitor the contracts, provide feedback reports, assure outputs and outcomes are met, and assure that the contract partners conduct appropriate day-to-day coordination at the service sites.

The HHOT is envisioned to have two main arms that correspond to the two geographic target areas for addressing chronic homelessness: Seattle and South King County.

Seattle: The HHOT in Seattle will include nursing, chemical dependency, and mental health staff. HHOT staff will travel to different housing sites and provide home-based visits and care to residents, as well as technical assistance for building staff. Functions will include screening and assessment, linkage to a primary care home, chronic care management, support for medication adherence, direct nursing care under protocols, motivational interviewing, linkage to substance abuse and mental health services on or off-site, or both, help accessing and maintaining Medicaid coverage, and health education groups. Residents who are eligible for publicly funded mental health services will be linked to care through the Regional Support Network for mental health, while those not eligible will receive limited support from the team's mental health professional.

South King County: V-HS Levy funds will provide funding for 1.0 FTE nurse position to provide services to several supportive housing projects that have either just opened or will soon open in South King County. At this time, most of the organizations serving chronic homeless people in south county are licensed mental health/substance abuse agencies, so the primary need is for a nurse to support the tenants. Two known projects are in place to serve high need, chronically homeless families and this nurse could be part of the team of those programs,[1] among others. As south King County continues to develop additional housing to serve high need homeless people, this program component could expand if needed.

[1] Family Services' project in Skyway (10 units); and Valley Cities Counseling & Consultation Pathways First project in Federal Way (14 units).

7. Coordination/Partnerships and Alignment Within and Across Systems

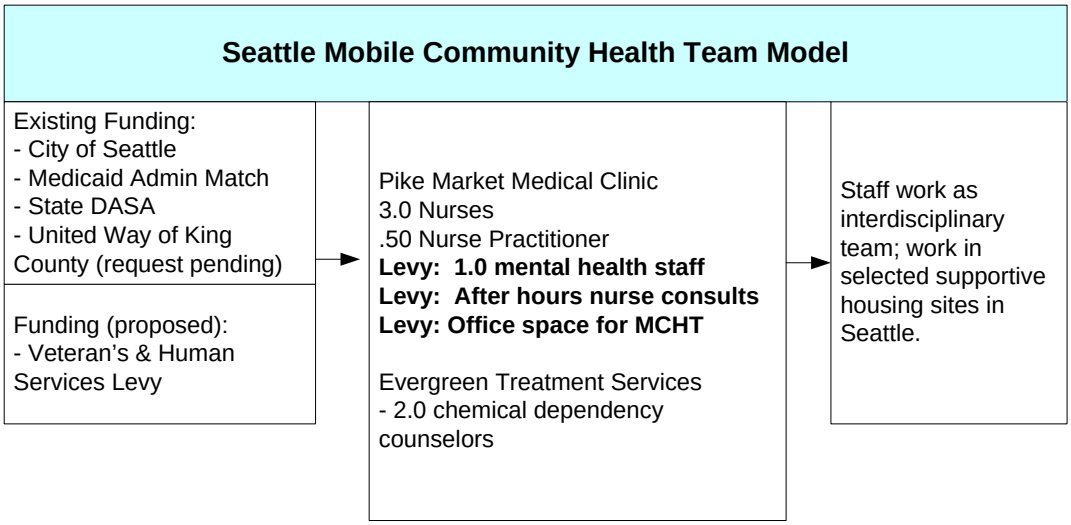
HCHN staff and its contract partners participate actively in the planning groups related to the *Ten-Year Plan to End Homelessness in King County* and the V-HS Levy. The sites to be served by the HHOT will be coordinated with the housing sites that are being funded through the fall joint NOFA.

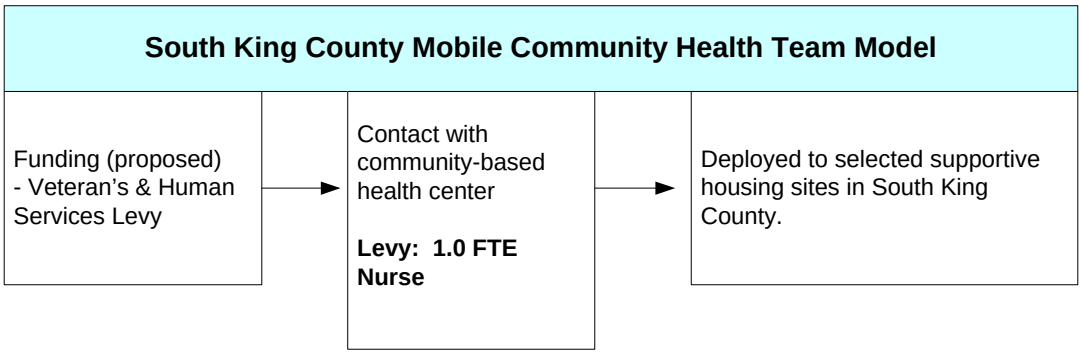
The development of the HHOT is well-aligned with the many other housing development and case management programs that are being developed in Seattle-King County to address chronic homelessness. It currently collaborates with the Seattle Human Services Department, Seattle Office of Housing, King County Department of Community & Human Services, Health Care for the Homeless Network of Public Health-Seattle & King County, Puget Sound Neighborhood Health Centers, Evergreen Treatment Services' REACH program, non-profit low-income housing developers, and other agencies serving this population. The project will also work coperatively with other new case management programs coming on line in our community, such as the King County Mental Health and Chemical Dependency Divisions' new treatment teams that will provide intensive services to clients in permanent housing. The HHOT staff will coordinate to learn which clients are receiving case management through the mental health system and will be able to coordinate with them, but not duplicate services. Adding the south King County component would be accomplished by contracting with a health center serving that area.

The HHOT began initial services in April 2007 as a result of an investment from the City of Seattle as part of its 2007 Housing First initiative. HCHN recently completed a competitive process and selected Puget Sound Neighborhood Health Center's (PSNHC) Pike Market Medical Clinic as the health care partner. Three nurses will work as part of the team, helping link clients to primary medical care in clinics of their choice. Another member of the HHOT partnership already in place is King County DCHS, whose drug and alcohol program successfully approached the Washington State Division of Alcohol and Substance Abuse (DASA) for the commitment of at least one chemical dependency professional who will work as part of the interdisciplinary team with the nurses to provide treatment for Medicaid-eligible residents. DCHS will contract with Evergreen Treatment Services for this position.

Another anticipated partner in the HHOT is United Way of King County, which is currently reviewing a request to add another substance abuse position to the HHOT. This position would have the flexibility to provide services to those who are not eligible for Medicaid, and would also be hired through Evergreent Treatment services to allow for coordination with DASA-funded position.

The graphic on the following page depicts the existing partners and staff levels of the HHOT, and shows where Levy funds would be applied to "round out" the HHOT interdisicplinary model.





Note: All contracts will be managed by Public Health – Health Care for the Homeless, except for the DASA-funded chemical dependency counselor, which will be managed by King County Department of Community & Human Services. However, all members of the HHOT will work together as an interdisciplinary team.

8. Timeline

Activity	Date
Request for Proposal to select health care partner for the Seattle HHOT	April 2007 (completed)
Seattle HHOT begins partial services	May 1, 2007
Mental health staff recruitment for Seattle Team; nurse recruitment for South King County; contracting processes	December 2007
Levy-funded services begin	January 2008

9. Selection of Projects/Activities

HCHN contracts with community-based organizations to provide services, using periodic competitive procurement processes to select contract partners. HCHN will have separate processes for Seattle and South King County as follows:

1. For the Seattle team, an RFP process was just competed to select the HHOT partner for Seattle. Pike Market Medical Clinic was selected, and has the ability to expand the team to add the mental health position and after-hours nursing consultation. It is important to build on the same organization for continuity of care and ease of information-sharing.
2. For launching South King County services, HCH will run an RFP process for the contract with a health center that provides primary care to low-income people in south King County, if there are multiple organizations who could provide the service.

10. Geographic coverage

The HHOT will initially focus on two areas that the Veterans & Human Services Levy SIP has designated for addressing chronic homelessness: Seattle and South King County. The model can readily be expanded to serve housing first or supportive housing projects that may come on-line in east or north King County.

11. Funding/Resource Leverage

The HHOT has already assembled $491,346 to support its implementation in Seattle from four fund sources: the City of Seattle; United Way of King County, Washington State Division of Alcohol and Substance Abuse; and Medicaid Administrative Match.

The Medicaid Administrative Match is a program that PH - SKC, as a local public health jurisdiction, participates in. The federal government matches a portion of the costs of certain activities related to helping people access Medicaid coverage and link to Medicaid services. Many homeless people are eligible for Medicaid, and many of the activities of the HHOT relate to helping people link to a primary care provider and health services, so HCHN is able to be reimbursed some of its costs through the Medicaid Administrative Match program.

Proposed use of Veterans & Human Services Levy funds within the Mobile Community Health Team:

Levy funds would complete the initial implementation of the HHOT by filling the remaining gaps in the Seattle team, and by launching the service in south King County. By strategically building upon this partnership, the HHOT would meet the SIP's criteria that call for "filling existing gaps in services and continuums of care, rather than creating new programs that promote systems fragmentation" and to "promote services and systems integration by challenging existing fragmentation". The HHOT is working to "braid" funds from multiple sources and the Levy funds would add to this program, which other key funders are already supporting.

The budget below shows the projected revenues and expenses associated with this portion of levy funds.

Mobile Community Health Team in PSH - Proposed Expansion With Levy Funds

REVENUE	
Proposed Amount - Veterans	75,000.00
Proposed Amount - Others in Need	175,000.00
Total Levy $ (from Supportive Services Line)	**250,000.00**
Estimated Medicaid Administrative Match @ 10%	25,000.00
Total Revenue	**275,000.00**
EXPENSES	
Contracts for services (see detail below)	224,000.00
HCH data collection & reporting	5,000.00
Public Health - Indirect	46,000.00
Total Expenses	**275,000.00**
Contracts: Projected Amounts, Subject to Final Negoitation	
Mental health specialst & benefits (Pike)	*70,760*
Psychiatrist consult/supervision (Pike)	*5,000*
After hours nurse consultation for MCHT (Pike)	*5,000*
MCHT Space (1500 sq ft @ 12.50/square ft)	*20,000*
South County Nurse - Sal/Ben	*75,000*
Other costs: Supplies, Cells, Training, Pharmaceuticals, Mileage, Indirect costs, etc.	*48,240*
Total	***224,000***

12. Evidence-based Best Practices

The Corporation for Supportive Housing has stated that "supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives". It is designed to help those who face complex challenges by providing access to a flexible array of comprehensive services including medical and wellness, mental health, substance use management and recovery, vocational and employment, money management, life skills, household establishment, and tenant advocacy. Studies have shown that housing first and permanent supportive housing positively impact the health of homeless households, including decreases in emergency room visits and hospital inpatient days, and increases in the use of preventive health care services. Levy funds will be invested in this model through coordination of the funding sources needed to make permanent supportive housing successful.

In implementing on-site health services, Health Care for the Homeless Network uses best practices in care delivery techniques. For example, all members of the HHOT will receive training in motivational interviewing, a proven method for enhancing motivation to change. Staff also work with clients with chronic health conditions to set self-management goals. Self-management support is one of the six areas in the Chronic Care Model advanced by the Institute for Health Care Improvement and the national Health Disparities Collaboratives designed to encourage high-quality chronic disease management (Glasgow RE, Davis CL, Funnell MM, Beck A. Implementing practical interventions to support chronic illness self-management. *Joint Commission Journal on Quality and Patient Safety*. 2003 Nov; 29(11):563-574).

13. Disproportionality Reduction Strategy

In King County's homeless population, people of color are over-represented relative to their proportion in the general population. According to the One Night Count, 58 percent of those counted were persons of color. In the HCHN, services are organized to appropriately reach the broad population of homeless people. In 2006, 55 percent of the clients served were from racial and ethnic minority communities, confirming that HCHN is reaching a cross-section of the homeless population. HCHN addresses disproportionality by addressing racial and ethnic health care disparities in all levels of its program, from the overall model to specific best practices used in service delivery. These are described in the following section.

14. Dismantling Systemic/Structural Racism

It is well documented that racial and ethnic minorities receive lower-quality health care than white people. The structure of standard health systems themselves contribute to racial and ethnic disparities in health care (*Unequal Treatment*, Institute of Medicine, 2002). Therefore, the core of Health Care for the Homeless Network's dismantling racism strategy is to apply a program model that works directly to overcome the barriers inherent in the model of more traditional clinic operations by taking the services to where homeless people are located—in shelters and supportive housing sites—and delivering services using techniques recommended for reducing racial and ethnic health disparities.

In *"Racial stereotyping and medicine: the need for cultural competence"* (CMAJ, June 12, 2001; 164 (12)), Jack Geiger notes that in many cases, disparities in diagnosis and treatment may not reflect conscious racial bias. "Time pressure and cognitive complexity (the need to think about many tasks at once) stimulate stereotyping…" Further, many minority patients have distrust for the health care establishment. The HHOT model is designed to address both conscious *and* unconscious biases by taking services into non-traditional settings where relationships and trust between clients and care providers can be built over time. The HHOT team staff has more time to spend with individual and group clients than a health care provider working in a clinic. For example, they can help explain to a client what diabetes is, support clients in establishing their own health goals and participating in the management of their health conditions, explaining medications, and supporting clients in the process of selecting and using a primary care medical home of their choice.

Other elements of the HHOT design incorporate specific recommendations made in "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (Institute of Medicine, 2002). They include: (1) Implement multidisicplinary treatment and preventive care teams. HHOT operates using a multidisicplinary team approach. (2) Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions. HHOT will offer in-person and group educational sessions designed to empower clients as active participants in decisions about their health care. (3) Support the use of community health workers. The project staffing model has many characteristics similar to that of community health workers in that assistance in provided with making and keeping appointments, escorting people to clinics if needed, and providing health education.

15. Cultural Competency

In the Health Care for the Homeless Network, services are organized to appropriately reach the population of homeless people. In 2006, 55 percent of the clients served in were from racial and ethnic minority communities, confirming that HCHN is reaching a cross-section of the homeless population. HCH addresses disproportionality by addressing racial and ethnic health care disparities in all levels of its program, from the overall model to specific best practices used in service delivery. These are described in the following section.

With over half of the target population estimated to come from racial and ethnic minority communities, primarily African American, Native American, and Hispanic communities. The HHOT is specifically designed to provide a model of culturally appropriate services. The proposed contract partners in the HHOT all have strong recruitment processes that reach out to people from diverse backgrounds, and efforts will be make to recruit staff that reflect the population to be served. However, it remains highly problematic in our region that minorities are under-represented in the health professions relative to their proportions in the general population. Contract partners have strong programs for promoting cultural competency through continuing education opportunities, and provide access to interpretation services.

Health Care for the Homeless Network is committed to implementation of the U.S. Department of Health and Human Services - Office of Minority Health's national standards for Culturally and Linguistically Appropriate Services (CLAS standards). Specific ways in which the standards have practical application in the HCH program include:

- Health Care for the Homeless advisory board is 50 percent people of color, including 4 individuals who are currently or formerly homeless (leadership reflects demographics of the population served).
- HCH staff—both administrative and direct service—receive regular opportunities to attend Undoing Institutional Racism trainings and cultural competency trainings.
- When conducting community assessments and program evaluations, HCH works with organizations that serve homeless people of color for support in designing and implementing culturally appropriate assessment activities. We sponsor focus groups / talking circles, provide translation and interpretation services, translate written materials into Spanish or other languages, and actively involve homeless consumer representatives in helping facilitate discussions and in analyzing assessment results.

16. Improvement in Access to Permanent Housing and Supportive Services

As discussed under items #13 and #14, the model of the HHOT is one that takes services to where people are living, and working with them to build relationship around addressing their health issues. This is a dramatically different type of access to health services than handing a chronically homeless person the phone number of a clinic and expecting them to successfully manage their health care.

17. Outcomes

The HHOT will, at a minimum, track and report on the following outcomes through a common "report card" that will be used for all funders.

1. Residents will improve their access to and use of regular, community-based primary health care services. Linkage to a primary care provider has been shown to reduce the

utilization of costly emergency room visits. Measure by tracking the number of participants who are successfully linked to a primary care provider and engaged in primary care.

2. Residents with mental health and/or substance abuse conditions, dental care needs, and/or tobacco use will engage in services for those conditions. Measure by tracking referrals made and referrals completed.
3. Residents will improve the management of their chronic health conditions. Measure by tracking the percentage of participants who set at least one self-management goal.
4. Eligible residents will be successfully enrolled in medical coverage. Measure by tracking the number of participants who have been assessed for benefits, and numbers successfully enrolled.
5. Residents will remain in stable housing. Measure by length of time in housing. Improved housing stability is a fundamental goal of the housing first/supportive housing model, and the entire HHOT together with the housing staff are expected to work jointly toward a model that achieves this goal. It is most likely that data tracking and reporting on this measure, however, will be the responsibility of the housing partners, not the health system partners (see "Medium term outcomes" above).

18. Process and Outcome Evaluation

The investment strategy to increase permanent housing with supportive services for veterans and other persons in need will be evaluated on both process and outcomes by evaluators hired in the DCHS, Community Services Division. HCHN will work with the evaluators to measure the effect of the Levy on process issues such as startup activities, contracting processes, collaboration and system level changes that occur, and on the outcomes listed above. Typical outcomes of supportive housing programs are residential stability and reduced use of emergency medical services, both of which are in alignment with the overall goals of the Levy.

In addition, HCHN is currently in the process of seeking additional, non-levy funding for a specific process and outcome evaluation for the HHOT. It will most likely be conducted by the Public Health—Seattle & King County Epidemiology, Planning, and Evaluation group. If funded, the evaluation design will be coordinated with the evaluation framework for the V-HS levy.